MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 INSTITUTIONAL ENCOUNTER ADDENDA VERSION 4010A1

Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)

May 21, 2004

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837 (004010X096)** dated May 2000. This document should be used in conjunction with all MDCH encounter submission and processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837 (004010X096)** ("Version 4010"), unless otherwise noted (with an asterisk (*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096A1).**

Page	Loop	Segment	Data Element	Comments
56		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide. Submissions with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected.
59		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use "RP" – Reporting.
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use "004010X096A1" if using October 2002 Implementation Guide.
63	1000A	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender's Code).
68	1000B	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use "D00111" for MDCH.
69	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
12*	2000A – Billing/Pay-to Provider Hierarchical Level	PRV – Billing/Pay-to Provider Specialty Information	PRV03 – Provider Taxonomy Code	Use taxonomy codes from the Health Care Provider Taxonomy Code List (provider specialty code), which is available at www.wpc-edi.com.
77	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use "24" (EIN) or "34" (SSN).
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the EIN or SSN value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier).
83	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D" (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use "0B" (State License Number).

Page	Loop	Segment	Data Element	Comments
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
102	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH's level of responsibility use "S" if the capitated plan is the only payer (that is, patient has no other insurance), "T" if there are any other payers.
103	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use "MICHILD" for children enrolled in the MIChild Program. Use "ABWI" for those enrolled in the Adult Benefit Waiver I program.
104	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use "MC" (Medicaid) for Michigan Medicaid, "TV" (Title V) for CSHCS, "OF" (Other Federal) for MIChild and ABWI, or "11" (Other Non-Federal) for persons who are not enrolled in Medicaid. If recipient qualifies for more than one program, or other MDCH program not listed, use "MC" (Medicaid).
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification).
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient's 8-digit beneficiary ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker. For other persons not enrolled in Medicaid or MIChild, use the patient's Social Security Number. Use the capitated plan's unique identifier assigned to the patient **only** when the person is not enrolled in Medicaid or MIChild and the Social Security Number is unknown.
117	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY" (Social Security Number).
118	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Use the patient's Social Security Number. Report this value even when used in 2010BA NM109 – Subscriber Primary Identifier.
127	2010BC – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use "PI" (Payor Identification).
128	2010BC – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use "D00111" for MDCH.

Page	Loop	Segment	Data Element	Comments
139	2000C – Patient Hierarchical Level			MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.
157	2300 – Claim Information			Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Level) will be rejected.
157	2300 – Claim Information	CLM – Claim Information	CLM02 – Total Claim Charge Amount	Report the total amount of all submitted charges for this encounter. A value of zero "0" may be reported.
159	2300 – Claim Information	CLM – Claim Information	CLM05-1 – Facility Code Value	Place of service codes are defined by the Center for Medicare and Medicaid Services (formerly HCFA). These codes can be obtained at cms.hhs.gov/state/poshome.asp
159	2300 – Claim Information	CLM – Claim Information	CLM05-3 – Claim Frequency Type Code	Use "1" on original encounter submissions; use "7" for encounter replacement, and use "8" for encounter void/cancel. For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop 2330B REF02 (Original Reference Number).
176	2300 – Claim Information	CN1 – Contract Information	CN101– Contract Type Code	Report this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.
208	2300 – Claim Information	NTE – Billing Note	NTE01 – Note Reference Code	Use "ADD" (Additional Information).
209	2300 – Claim Information	NTE – Billing Note	NTE02 – Billing Note Text	Provide free-text remarks, if needed.
230	2300 – Claim Information	HI – Health Care Information	HI01-2 – Diagnosis Related Group (DRG) Code	Report the DRG Code when an inpatient hospital is under DRG contract with the health plan.
232-240	2300 – Claim Information	HI – Health Care Information	HI01-1, HI02-1, . . . , HI12-1 – Diagnosis Code	Use "BF" (ICD-9-CM Diagnosis). Do not use decimal point.
242	2300 – Claim Information	HI – Principal Procedure Information	HI01–1 – Code List Qualifier Code	Use "BR" (ICD-9-CM Principal Procedure).
242	2300 – Claim Information	HI – Principal Procedure Information	HI01–2 – Principal Procedure Code	See the ICD-9 CM Code book for allowable procedure codes.

Page	Loop	Segment	Data Element	Comments
244 – 255	2300 – Claim Information	HI – Other Procedure Information	HI0–1, HI02–1, …, HI12–1 – Code List Qualifier Code	Use “BQ” (ICD-9-CM Procedure).
245 – 255	2300 – Claim Information	HI – Other Procedure Information	HI01–2, HI02–2, …, HI12–2 – Procedure Code	See the ICD-9 CM Code book for allowable procedure codes.
256 – 266	2300 – Claim Information	HI – Occurrence Span Information	HI01–2, HI02–2, ..., HI12–2 – Occurrence Span Code	See the National Uniform Billing Manual for allowable codes.
268 – 278	2300 – Claim Information	HI – Occurrence Information	HI01–2, HI02–2, ..., HI12–2 – Occurrence Code	See the National Uniform Billing Manual for allowable codes.
281 – 291	2300 – Claim Information	HI – Value Information	HI01–2, HI02–2, ..., HI12–2 – Value Code	See the National Uniform Billing Manual for allowable codes.
290	2300 – Claim Information	HI – Condition Information	HI01–2, HI02–2, ..., HI12–2 – Condition Code	See the National Uniform Billing Manual for allowable codes.
323	2310A – Attending Physician Name	NM1- Attending Physician Primary Identifier	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
323	2310A – Attending Physician Name	NM1- Attending Physician Primary Identifier	NM109 – Attending Physician Primary Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310A REF02 (Attending Physician Secondary Identifier).
21*	2310A – Attending Physician Name	PRV – Attending Provider Specialty Information	PRV03 – Provider Taxonomy Code	Use taxonomy codes from the Health Care Provider Taxonomy Code List (provider specialty code), which is available at www.wpc-edi.com.
326	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
327	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF02 – Attending Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.

Page	Loop	Segment	Data Element	Comments
330	2310B – Operating Physician Name	NM1- Operating Physician Primary Identifier	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
330	2310B – Operating Physician Name	NM1- Operating Physician Primary Identifier	NM109 – Operating Physician Primary Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310B REF02 (Operating Physician Secondary Identifier).
333	2310B – Operating Physician Name	REF – Operating Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
334	2310B – Operating Physician Name	REF – Operating Physician Secondary Identification	REF02 – Operating Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
337	2310C – Other Provider Name	NM1 – Other Provider Primary Identification	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
337	2310C – Other Provider Name	NM1 – Other Provider Primary Identification	NM109 – Other Provider Primary Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310C REF02 (Other Physician Secondary Identifier).
340	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
341	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF02 – Other Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
350	2310E – Service Facility Name	NM1 – Service Facility Primary Identification	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
350	2310E – Service Facility Name	NM1 – Service Facility Primary Identification	NM109 – Laboratory or Facility Primary Identifier	Use the EIN or SSN value assigned to the provider identified in Loop 2310E REF02 (Service Facility Secondary Identifier).

Page	Loop	Segment	Data Element	Comments
357	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number).
358	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF02 – Laboratory or Facility Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID) unless the facility does not have a Medicaid ID.
359	2320 – Other Subscriber Information	SBR – Subscriber Information		Community Mental Health encounters requires this loop once for the Prepaid Inpatient Health Plan (PIHP) and once for the Community Mental Health Service Program (CMHSP) Affiliate, where applicable. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop.
360	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code “P” or “S” as appropriate, and the capitated plan coverage with “S” or “T”, as appropriate. If the patient has no other insurance, report the capitated plan coverage with “P”.
361	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid has coverage under his father’s insurance, use code 19 (Child).
363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Community Mental Health encounters should report “MC” for Medicaid Fund and “11” (Other Non-Federal) for General Fund.
365	2320 – Other Subscriber Information	CAS – Claims Adjustment		MDCH expects claim adjustment information when adjudication has taken place at the claim level and the value reported in Loop 2320 AMT02 (COB Payer Prior Payment) is not equal to the value reported in Loop 2300 CLM02 (Total Claim Charge). MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference.
371	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT01 – Amount Qualifier Code	Use “C4” (Prior Payment – Actual)

Page	Loop	Segment	Data Element	Comments
371	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT02 – Payer Prior Payment	Report the amount the payer has paid to the provider towards the services reported in the encounter. A value of "0" may be reported.
372	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT01 – Amount Qualifier Code	Use "B6" (Allowed - Actual).
372	2320 – Other Subscriber Information	AMT – Monetary Amount	AMT02 – Allowed Amount	MDCH requires the PIHP calculated approved (allowed) amount for all services reported. Use this amount for the total claim level charges allowed. A value of zero "0" should not be reported.
401 – 402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105 – Other Insured: Last Name, First Name, Middle Name	Use the name of the subscriber as it appears on the files of the capitated plan or other payer.
401 – 402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI" (Member Identification Number).
403	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the PIHP, CMHSP or other payer indicated in Loop 2330B. For PIHPs and CMHSPs this is an 11-character "CON" ID. For BCBSM members, the numbers assigned are usually 3 letters followed by 9 digits.
408	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use "1W" (Member Identification Number).
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use "PI" (Payor Identification).
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the PIHP/CMHSP, use the 9-digit Payer ID assigned by MDCH. For example "171234567". For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be "00029005". For Medicare Part A (United Government Services) use "00452". For Medicare Part B (Wisconsin Physician Services) use "00953".
416	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF01 – Reference Identification Qualifier	For the capitated plan, use "F8" (Original Reference Number).

Page	Loop	Segment	Data Element	Comments
417	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF02 – Other Payer Secondary Identifier	For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.
418	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	Use “9F” (Referral Number) or “G1” (Prior Authorization Number).
419	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number (Loop 2300 REF02 – Prior Authorization or Referral Number), which is specific to the destination payer.
426	2330D – Other Payer Attending Provider	REF – Other Payer Attending Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
430	2330E – Other Payer Operating Provider	REF – Other Payer Operating Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
434	2330F – Other Payer Other Provider	REF – Other Payer Other Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
438	2330G – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
442	2330H – Other Payer Service Facility Provider	REF – Other Payer Service Facility Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D” (Medicaid Provider Number).
444	2400 – Service Line			The HIPAA implementation guide allows up to 999 repetitions of the 2400 service line loop for each 2300 loop.
446	2400 – Service Line	SV2 – Institutional Service Line	SV201 – Service Line Revenue Code	Use the PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes list posted on MDCH website.

Page	Loop	Segment	Data Element	Comments
447	2400 – Service Line	SV2 – Institutional Service Line	SV202-2 – Procedure Code	Use the PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes list posted on MDCH website.
448	2400 – Service Line	SV2 – Institutional Service Line	SV203 – Line Item Charge Amount	Use the provider's usual and customary charge or billed amount. A value of zero (0) may be reported.
35*	2410 – Drug Identification	LIN – Drug Identification	LIN03 – National Drug Code	This element may be used to report prescribed drugs that may be part of the service(s) described in Loop 2400 SV2 (Institutional Service). MDCH will only process the first iteration of Loop 2410 LIN (Drug Identification). Any additional repeats may be ignored.
490	2430 – Service Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in loop 2320 (Other Subscriber Information), except for when the payer has adjudicated this claim at the claim level.
491	2430 – Service Line Adjudication Information	SVD – Service Line Adjudication	SVD02 – Service Line Paid Amount	Report the amount paid to the provider. A value of zero "0" may be reported.
494	2430 – Service Line Adjudication Information	CAS – Claims Adjustment		MDCH expects claim adjustment information when adjudication has taken place at the service line level and the value reported in Loop 2430 SVD02 (Service Line Paid Amount) is not equal to the value reported in Loop 2400 SV203 (Service Line Item Charge Amount). MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference.